# Medical Information & Emergency Release Form (2023-2024)

Return to healthandwellness@gracechristiansanford.com before the first day of school.
This release is **required for the student to participate in athletics, field trips, camps or retreats**.

**STUDENT INFORMATION**

______________________ /______________________ /______________________ /______________
Last Name First Name Middle Name Preferred

Address: ______________________________ City: ______________ State: ______ Zip: ________

Student Cell: ____________________ Grade: ______ Date of Birth: ___ /___ /___ Gender: ___ M ___ F

**EMERGENCY CONTACTS**

Name: ______________________ Relation: ______________ Phone: ______________

Name: ______________________ Relation: ______________ Phone: ______________

Name: ______________________ Relation: ______________ Phone: ______________

Name: ______________________ Relation: ______________ Phone: ______________

| HEALTH PROVIDER | NAME | PHONE |
|---|---|---|
| Primary Care Provider | | |
| Preferred Hospital | | |
| Dentist | | |

Insurance Company: ____________________________________________

Policy Number: ______________________ Phone: ______________________

In case of an accident or serious illness, the school will attempt to contact the parent/guardian. If the school is unable to contact the parent/guardian, or emergency contacts designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.

**STUDENT HEALTH HISTORY**

List any health information past and present (i.e. diabetes, asthma, allergies, seizures, migraines, AD/ADHD, etc.) as well as any medications that your student is currently taking, even if they are not administered at school:

________________________________________________________________

________________________________________________________________

________________________________________________________________

*I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.*

**PARENT/GUARDIAN NAME:** ____________________ **SIGNATURE:** ____________________ **DATE:** __________

# Medication Authorization Form (2023-2024)

Required **ONLY if medication is to be administered** during school or school-sponsored events.
Return to the school office or healthandwellness@gracechristiansanford.com.
Medications must be in original packaging and will be disposed of if not picked up by May 31, 2024.

Student Name: ______________________________ Grade: __________

Physician/CRNP/PA Name: ______________________________ Phone: ______________________

**OVER-THE-COUNTER (OTC) MEDICATIONS** that specifically may or may not be administered to this student:

| MEDICATION NAME | PERMITTED? | DOSE | INDICATIONS / COMMENTS |
|---|---|---|---|
| Tylenol (acetaminophen) | ____ YES ____ NO | | |
| Motrin (ibuprofen) | ____ YES ____ NO | | |
| Benadryl (diphenhydramine HCl) | ____ YES ____ NO | | |
| | ____ YES ____ NO | | |
| | ____ YES ____ NO | | |

**PRESCRIPTIONS MEDICATIONS** that should be administered to this student as indicated or per defined schedule:

| MEDICATION NAME | DOSAGE / ROUTE | SCHEDULE / DURATION / INDICATIONS | POSSIBLE SIDE EFFECTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**EMERGENCY MEDICATIONS** (i.e. EpiPen, inhaler, etc.) may be carried by the student and self-administered if the physician indicates the student is sufficiently responsible. Parents should supply the school with additional emergency medications as a precaution.
A physician's **Action Plan** is recommended for students with a history of asthma, diabetes, allergic reactions or seizures requiring treatment.

Does the student carry and self-administer medication for emergencies? ____ Yes ____ No

Allergies or conditions that may require emergency medication: ______________________________

______________________________________________________________

**Physician/CRNP/PA Signature:** ______________________________ **Date:** ______________

*The above medication order is valid 8/15/2023 – 8/15/2024*

**PARENT/GUARDIAN AUTHORIZATION**

*I hereby request the medication(s) listed above be given as required to this student during school hours and school-sponsored events. I understand that only the parent/guardian, school nurse, or appointed school personnel may administer this medication. I acknowledge that the school shall incur no liability as a result of any condition from the medication. I shall not hold the school, its employees or agents against any claims arising from the administration of medication given to this student.*

**PARENT/GUARDIAN NAME:** ____________________ **SIGNATURE:** ____________________ **DATE:** __________